Highlights in this issue

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Mohammad *et al.*, p. 291

Pilgrim *et al.*, p. 333

Renal dysfunction and resection of hepatoma

Our associate editor, Steve Wigmore, will be back with an editorial highlight soon when he returns form the Pacific Ocean! The current report from *Toshima and colleagues* evaluates a group of patients who underwent resection of HCC to determine the influence of the presence of renal dysfunction on outcome. The Fukuoka team established that 17 of the 722 patients with renal dysfunction underwent liver resection over a 24 year period and that the overall and disease free survival was not impacted by the additional presence of renal dysfunction. However, hypoalbmuminaemia, blood loss and the need for blood transfusion did increase risk of complications such as fluid retention. Whereas potential interventions are proposed to limit risk in the patients with renal failure, the authors recognize the difficulties of drawing a significant conclusion even in this large cohort when there may have been some additional selection bias in the at-risk group. The results from this high volume centre may not readily translate globally and we need more data and more prospective interventional studies in this area.

James Garden

Liver specfic MRI prior to neoadjuvant chemotherapy for colorectal hepatic metastases is now the standard of care

In this issue of *HPB*, it is strongly recommended that all surgeons involved in hepatic resection of colorectal liver metastases read the article by *Knowles et al.* and the accompanying editorial by *McCall.* The group from Basingstoke, United Kingdom describe a large retrospective series of 242 patients who underwent neoadjuvant chemotherapy prior to hepatic resection for colorectal liver metastases. The authors divided the patients into two groups: those that received pre-chemotherapy liver specific MRI ($n = 92$) and those that did not ($n = 150$). The key findings in this paper were that the pre-chemotherapy MRI changed staging in 55% of patients and after long term follow up (median = 55 months) there was a higher incidence of new site intra-hepatic recurrence (65% vs. 48%, $P = 0.041$) and there was a higher rate of repeat hepatectomy (24.7% vs. 13%, $P = 0.04$) in those that did not have a pre-chemotherapy liver specific MRI as compared to those that did. Overall survival for both groups was similar. In an accompanying editorial, *McCall* correctly provides a detailed analysis of the strengths and weaknesses of the current study given that this would suggest a major change in practice for many hepatic surgeons. The editorial also highlights the challenges of instituting such a policy given the variable referral patterns of these patients to hepatic surgeons. Education at multi-disciplinary meetings by hepatic surgeons would seem to be an important way of changing practice. What also should not be forgotten is that, despite the best modern imaging, intra-hepatic recurrence rates within the liver are still significant with approximately 25% occurring within the first 12 months. This early recurrence would suggest that there is still room for significant improvement in imaging if long term outcomes are to be improved.

Saxon Connor

Patient selection for resection of pancreatic cancer

As pancreatic resection becomes safer, it is being offered to more and more patients, including the elderly and those with multiple co-morbidities. Careful and realistic patient selection is required to achieve proper outcomes, especially when resection is employed for pancreatic adenocarcinoma. In a retrospective study from Vancouver, *Eeson et al.* have identified clinical risk factors in 100 patients who underwent pancreaticoduodenectomy (PD) for ductal adenocarcinoma. Some factors were specifically associated with increased short-term (90 days) and long-term (5 years) mortality rates. Median survival was 16.5 months, with a total 5-year survival of 12%. Ninety-day mortality was 7%. Risk factors predictive of 90-day mortality included advanced age (>80 yrs) and an American Society of Anesthesiologists (ASA) score of 3. Survival at 5 years was significantly reduced for patients with ASA scores of 3 (the only predictive variable), and for those who suffered post-operative complications requiring invasive interventions. Neither chemotherapy/radiation therapy nor tumor biology factors (TMN, lymphovascular or perineural invasion) had significant effects on 5-year survival. Patients with node-negative or R0/R1 resections did survive longer, but eventually succumbed in most cases. These data yet again indicate that only a minor survival advantage can be achieved through resection of pancreatic cancer. Accordingly, it is imperative that surgeons advise and select their patients quite deliberately so as to minimize short- and longer-term morbidity and mortality. For patients not offered pancreatic resection for cancer, the emphasis must remain on optimal palliation and preserved quality of life.

Mark Callery